**Kevin M. Kirkland, D.M.D., P.C.**

Family Dentistry

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Office 770-227-8020

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***Financial Information for Our Patients***

Thank you for choosing Dr. Kevin Kirkland as your dental provider. We believe in comprehensive dental care and are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following includes financial information for you to read and sign prior to treatment. *All patients must complete required paperwork before seeing the doctor.*

**Payment is required at time of service.** We accept the following forms of payment:

**Cash, Check** (A service charge will apply to all returned checks), **MasterCard, Visa, American Express, and Care Credit**

***Approved financial options arranged prior to the beginning of treatment***

With cases such as crowns, bridges, partials, and dentures, 50% of the fee is due at the time treatment begins and the balance is due at the time of delivery.

***Dental Insurance***

As a courtesy we can assist you in obtaining the maximum benefit from your dental insurance plan. Filing insurance claims is a service provided without charge and in no way relieves you of responsibility for your bill. Please bring your insurance card with you each time you visit our office. We can estimate your portion of the charges on the date services are provided based on the information available. ***This amount is due when services are rendered***. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. Please become familiar with your policy exclusions, maximums, deductibles, and required coinsurance. **Any balance not paid by your insurance carrier within 45 days, becomes your responsibility.**

***Usual and Customary Rates*** We strive to provide the best treatment for our patients and our charges are usual and customary for our area. We are not a preferred provider with any insurance company, as we have found that participation as a preferred provider can limit our ability to provide the highest quality of care. You are responsible for payment regardless of any insurance company’s determination of usual and customary rates.

***Minor Patients***   
 The adults accompanying a minor and the parents or guardians of the minor are responsible for full payment. Non-emergency treatment will be denied unless a pre-approved payment method has been established.

***Appointments***

**48-hour notice** is required to change an appointment. If this notice is not provided, a fee may be charged.

***Delinquent Accounts*** A maintenance fee may apply to any balance over 30 days old. If collection action is taken the guarantor is responsible for all legal and collection fees.

I have read, understand, and agree to all the preceding information.

**SIGNATURE DATE:**\_\_\_\_\_\_\_\_\_\_

*Guarantor - Patient or Person financially responsible for the account if other than patient*

**PRINT NAME**